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M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal to, and receive a fair hearing before, the administering agency, *the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:*

- *takes an action to terminate, deny, suspend, or reduce benefits,*
- *fails to take an application for medical assistance,*
- *fails to act on an application for medical assistance with reasonable promptness, or*
- takes any other action that adversely affects receipt of medical assistance.

The State law governing the State/Local Hospitalization (SLH) program requires that the Department of Medical Assistance Services (DMAS) use the Medicaid applicant/recipient appeals and hearings procedures for SLH applicants and recipients. The procedures in this Chapter also apply to SLH appeals.

B. Participants

The Department of Medical Assistance Services provides the Hearing Officer who makes arrangements for the fair hearing. **The local agency taking the action being appealed, including MDU disability decisions**, and the appellant (the individual appealing some aspect of his entitlement to medical assistance or its scope of services) or his representative must participate in the hearing. *In certain circumstances, participation may be by telephone.*

C. Notification and Rights

1. Notification requirements

At the time of application or redetermination, and at the time of any action or proposed action affecting his eligibility for medical assistance or medical services, every applicant for and recipient of medical assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesman.

2. Notification forms

When the local social services department takes action on an individual's application for Medicaid, the following forms must be used:

a. form #032-03-008, “Notice of Action on Medicaid ...”, is used to notify an applicant of the action taken on his application or of failure to take action within **the appropriate time frame for the covered group.**

b. form #032-03-018, "Advance Notice of Proposed Action", is used to notify a recipient of a decision to cancel his Medicaid case, to cancel the coverage of an individual member of his case or to reduce the coverage from full to limited coverage. This notice must be mailed to the recipient at least 11 days (including the mailing date) before the effective date of the action.

1. The advance notice must include:

- a statement of the action to be taken.
- the *reason(s) for the* proposed action.
- a statement of the specific manual policy *citation* requiring this action.
- an explanation of the recipient's right to request an agency conference with the local agency and a fair hearing before the state agency.
- an explanation of his right, under specified conditions, to continued assistance during the fair hearing process.

2. The advance notice is not required when:

a) the recipient's whereabouts are unknown and agency mail to him has been returned by the Post Office with an indication that no forwarding address is known.

b) the recipient has been accepted for assistance in another locality and the agency has verified this fact.

c) the recipient has been approved as an Auxiliary Grant recipient and the Medicaid only case is statistically closed.

d) the recipient's Medicaid coverage is canceled automatically at the end of the spend-down period. An advance notice is required if the recipient becomes ineligible prior to the end of the spend-down period.

e) the recipient's Medicaid coverage is automatically canceled by the Medicaid computer. An advance notice from the local agency is required if the recipient becomes ineligible before the projected month of automatic cancellation. Medicaid is automatically canceled when the recipient no longer meets the category's age limit or pregnancy duration limit, when the 12-month extension or transitional period ends, or when the recipient does not return the earnings report in a timely manner.

3. Cancellation due to death

The "Notice of Action on Medicaid" form must be sent to a recipient's estate at the recipient's last known address, or to his authorized representative, when coverage is terminated as a result of the recipient's death. The effective date of cancellation must be the date of death.

M1620.100 LOCAL AGENCY CONFERENCE

A. Time Limits

A dissatisfied applicant or recipient must be given the opportunity to request a local agency conference. The conference must be scheduled within 10 working days of receiving a request for a conference.

B. Conference Procedures

At the conference, the applicant/recipient must be:

- given an explanation of the action.
- allowed to present any information to support his disagreement with the action.
- allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

C. Failure to Request a Conference

The applicant's or recipient's failure to request a conference does not affect his right to appeal to the State agency within 30 days and does not affect his right to continued eligibility if he appeals a proposed cancellation, *patient pay increase, or reduction of benefits from full coverage to limited coverage* prior to the effective date of the action.

D. The Conference/ Right to Appeal

The local agency conference must not be used to interfere with the appellant's right to a fair hearing before the State Department of Medical Assistance Services.

E. Decision Notification

1. The local agency conference may or may not result in a change in the agency's decision to take the action in question.

2. If the agency's decision is not to take the action indicated on the "Notice of Action on Medicaid" or on the "Advance Notice of Proposed Action", the applicant or recipient must be so advised in writing and a notation of the changed action must be entered on the agency copy of the notice. *A copy of the amended notice must be sent to DMAS.*

3. If the agency's decision is to stand by its action, the recipient must be so advised but written notice of this decision is not required.

F. Right to Appeal Conference Decision

If the recipient is not satisfied with the agency action following the conference and wants to request a fair hearing before the State agency, he must be given that opportunity and be given any needed assistance to file an appeal.

G. Reversal of Decision Prior to Appeal Decision

An agency can reverse its decision to deny, *reduce,* or terminate Medicaid at any time between making the original decision and when a decision is rendered by the Hearing Officer. Such a change may occur due to receipt of previously unavailable or unknown information, or reevaluation of the case circumstances. If the agency changes its decision, the applicant/recipient and the Hearing Officer must be notified in writing of the change. Send a copy of the notice to the Hearing Officer.

M1630.100 CONTINUED COVERAGE PENDING APPEAL DECISION

A. Coverage May Continue

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the agency. The agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the appellant is eligible to receive continued coverage, the agency must reinstate coverage immediately.

A recipient's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the "Advance Notice of Proposed Action" or the "Notice of Obligation for Long Term Care Costs".

B. Coverage Not Continued

Coverage will not continue until the final appeal decision when:

1. an appeal hearing is requested on or after the effective date of action;

2. an appellant does not dispute the facts used by the local agency, but is appealing the policy on which the agency based its action;

3. at the hearing, the Hearing Officer determines that the sole issue of the appeal is disagreement with existing State or Federal policy or law and that no facts are disputed. The Hearing Officer will *promptly* notify the appellant or his representative and the agency in writing that continued Medicaid coverage must terminate immediately. The agency shall terminate the recipient's Medicaid immediately, using cancel reason "15" effective the date of the hearing.

C. Recovery of Continued Coverage Costs

When the Hearing Officer upholds the agency's determination, the cost of medical care received during the period of continued coverage may be recovered by the DMAS. (See M1670.100)

M1640.100 APPEAL REQUEST PROCEDURES

A. Appeal Definition

1. An appeal is a request for a fair hearing. The request must be a clear, *signed* written expression by an applicant or recipient, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority.

2. The appeal request must be written. It may be a letter or a completed "Medicaid/SLH/*FAMIS* Appeal Request Form."

B. Where to File an Appeal

Appeals must be sent to the Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

C. Assuring the Freedom to Appeal

The freedom of appeal must not be limited or interfered with in any way. When requested to do so, the agency shall assist the appellant in preparing and submitting his request for a fair hearing.

D. Appeal Time Standards

1. A request for a hearing must be made within 30 days of receipt of notification that an application for medical assistance is denied, that it has not been acted upon with reasonable promptness, that a request for a medical service has been denied, or that the agency proposes to take any other action the will adversely affect receipt of medical assistance.

2. Notification is presumed received by the applicant/recipient within three days of the date the notice was mailed, unless the applicant/recipient substantiates that the notice was not received in the three-day period through no fault of his/her own.

3. The DMAS will, at its discretion, grant an extension of the time limit for requesting a fair hearing if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

E. Appeal Validation

1. Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request is valid and will notify the appellant of the status of the appeal. A valid appeal is one that appeals an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

2. When an appeal is found valid, the DMAS will notify the appellant and request an appeal summary from the appropriate local agency.

M1650.100 LOCAL AGENCY APPEAL SUMMARY

A. Procedures

Once an appeal of an agency action has been validated, the agency must complete an "Agency Appeal Summary," form #032-03-805 (see Appendix 1 to this chapter). At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:

1. Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

2. The local agency's assigned Medicaid Program *Consultant.*

3. The appellant or his authorized representative.

The agency must keep a copy of the appeal summary for its records.

M1660.100 THE HEARING PROCEDURE

A. The Hearing Officer

A qualified, impartial representative of the DMAS will conduct the hearing. This individual, the Hearing Officer, must not have been directly involved in the initial decision being appealed. The Hearing Officer will schedule the hearing at a time, date, and place convenient to the appellant and the involved agency. Some hearings may be held telephonically.

B. Hearing Procedure

To best serve the appellant's interest, the hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings

will be governed by the following rules:

1. *The Hearing Officer* will swear-in all hearing participants who will be presenting evidence or facts, and will record the hearing proceedings.

2. The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.

3. The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

C. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency or gathered by the Hearing Officer. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the correctness of the action being appealed.

2. Procedures

If the local department of social services denies an application because of failure to provide requested information, the hearing will address:

a. whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and

b. whether or not the applicant was given sufficient time to submit the information requested.

If the local department of social services followed correct procedures *(see M0130.200)* and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

If the hearing officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the hearing officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

3. Hearing Officer Decision

Examples of the Hearing Officer's decisions include but are not limited to, sustaining the agency action, reversing the agency action or remanding the case to the agency for additional evaluation.

Sustain — The Hearing Officer*'s decision* upholds the agency's action.

Reverse — The Hearing Officer's decision overturns the agency's decision.

Remand — The Hearing Officer's decision sends the case back to the agency for additional evaluation. The Hearing Officer's decision will include specific instructions that must be followed when completing the remand evaluation.

Upon examination of the summary submitted by the local agency, if it is determined that an obvious error or misunderstanding of policy has occurred *and that the case should be resolved in the applicant's favor*, the Hearing Officer has the authority to issue a judgement on the record instead of holding a hearing. The Hearing Officer will provide the local agency with a clear explanation of the reason(s) for issuing a judgement on the record and which actions must be taken by the local agency to correct the case. The decision to issue a judgement on the record is at the Hearing Officer's discretion.

D. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision. If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

1. Agency Action - Sustained Cases

Following a Hearing Officer's decision that a proposed agency action to cancel coverage is sustained, the case must be closed without an additional notice to the recipient from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation. The local agency must take action to close the case in the Medicaid computer using cancel reason "15"effective the date the agency receives the decision.

2. Agency Action- Remand Cases

a. If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.

b. If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.

c. If the remand evaluation results in the appellant's continuous eligibility and coverage was not continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of

his continued eligibility.

d. If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the case must be closed at the completion of the evaluation.

M1670.100 RECOVERY OF BENEFITS PAID DURING APPEAL

A. Applicable Circumstances

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

B. Recovery Period

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered. The expenditures will be recovered from the appellant, not the service provider.

AGENCY APPEAL SUMMARY

SECTION I: CASE IDENTIFICATION INFORMATION

CASE NAME:_____ CASE NUMBER: _____

SOCIAL SECURITY NUMBER:_____PHONE NUMBER: _____

ADDRESS: _____

_____

_____

_____

AGENCY: _____

WORKER NAME/PHONE NUMBER: _____

SUPERVISOR NAME/PHONE NUMBER: _____

SECTION II: GENERAL ELIGIBILITY INFORMATION

ACTION BEING APPEALED: (INCLUDE CASE SPECIFICS, I.E. APPLICATION DATE, HOSPITALIZATION OR SERVICE DATE, DENIAL/CANCEL REASON, VERIFICATION REQUEST DATE AND DUE DATE, ETC.):

_____

_____

_____

_____

DATE OF NOTIFICATION: _____

EFFECTIVE DATE OF PROPOSED ACTION: _____

DATE MEDICAID COVERAGE REINSTATED, IF APPLICABLE: _____

APPLICABLE POLICY (POLICY CITATION WITH BRIEF POLICY STATEMENT):

_____

_____

_____

AGENCY APPEAL SUMMARY

SECTION I: CASE IDENTIFICATION INFORMATION

CASE NAME:_____ CASE NUMBER: _____

SOCIAL SECURITY NUMBER:_____PHONE NUMBER: _____

ADDRESS: _____

_____

_____

_____

AGENCY: _____

WORKER NAME/PHONE NUMBER: _____

SUPERVISOR NAME/PHONE NUMBER: _____

SECTION II: GENERAL ELIGIBILITY INFORMATION

ACTION BEING APPEALED: (INCLUDE CASE SPECIFICS, I.E. APPLICATION DATE, HOSPITALIZATION OR SERVICE DATE, DENIAL/CANCEL REASON, VERIFICATION REQUEST DATE AND DUE DATE, ETC.):

_____

_____

_____

_____

DATE OF NOTIFICATION: _____

EFFECTIVE DATE OF PROPOSED ACTION: _____

DATE MEDICAID COVERAGE REINSTATED, IF APPLICABLE: _____

APPLICABLE POLICY (POLICY CITATION WITH BRIEF POLICY STATEMENT):

_____

_____

_____

_____

PAGE 2

DATE OF PRE-HEARING CONFERENCE. INDICATE CONFERENCE RESULTS:

_____

_____

_____

_____

IDENTIFY AND ATTACH THE FOLLOWING:

1. NOTIFICATION OF ACTION, DENIAL, TERMINATION, ETC.
2. MEDICAID REINSTATEMENT NOTICE, IF APPLICABLE
3. WORKER'S ELIGIBILITY EVALUATION
4. VERIFICATION OF INCOME AND/OR RESOURCES
5. SOCIAL SECURITY DOCUMENTS
6. DEEDS AND WILL, TAX TICKETS
7. OPINIONS OF REGIONAL PROGRAM COORDINATOR AND ATTORNEY GENERAL
8. RELEVANT CASE NOTES AND CORRESPONDENCE
9. APPLICATION/(PAGES APPLICABLE TO MEDICAID)

MEDICAID/SLH FAMILY UNIT COMPOSITION (LIST APPELLANT'S NAME FIRST, SPOUSE NEXT, CHILDREN LAST)

NAME	RELATIONSHIP	DOB	CATEGORY

LIST ADDITIONAL MEMBERS OF HOUSEHOLD NOT PART OF FAMILY UNIT:

_____

_____

_____

PAGE 3

SECTION III: CASE SUMMARY INFORMATION

FINANCIAL INFORMATION: IDENTIFY ALL SOURCES OF INCOME AND THE AMOUNTS.

NAME	INCOME TYPE	AMOUNT	VERIFIED BY

IDENTIFY AND SPECIFY INCOME LIMIT APPLIED:

_____

_____

SHOW ALL COMPUTATIONS OF HOW COUNTABLE INCOME FIGURE ACHIEVED. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

IDENTIFY SPEND DOWN PERIOD, IF APPLICABLE.

_____

_____

RESOURCE INFORMATION: IDENTIFY ALL PROPERTY AND THE AMOUNTS.

OWNER'S NAME	PROPERTY	ASSESSED VALUE	COUNTABLE VALUE	VERIFIED BY

PAGE 4

SHOW ALL COMPUTATIONS OF HOW COUNTABLE VALUE ACHIEVED. (ATTACH ADDITIONAL SHEET IF NECESSARY.)

IDENTIFY AND EXPLAIN WHICH REAL OR PERSONAL PROPERTY EXEMPTIONS DID OR DID NOT APPLY.

_____

_____

_____

_____

BURIAL SET ASIDE COMPLETED? RESULTS:

_____

_____

RESOURCE ASSESSMENT COMPLETED? RESULTS:

_____

_____

TRANSFER INFORMATION: IDENTIFY ALL TYPES OF ASSETS TRANSFERRED AND AMOUNTS.

DESCRIPTION TRANSACTION TRANS. BY TRANS. TO AMOUNT

_____

_____

_____

_____

DATE OF INSTITUTIONALIZATION: _____

PAGE 5

IDENTIFY AND EXPLAIN WHY EACH TRANSFER EXCEPTION WAS NOT MET OR DID NOT APPLY.

_____

_____

_____

_____

IDENTIFY UNCOMPENSATED VALUE AND INELIGIBILITY PERIOD:

_____

_____

_____

_____

SECTION IV: CASE NARRATIVE

INCLUDE A BRIEF CASE SUMMARY/SYNOPSIS OF AGENCY ACTION. (THIS SECTION IS OPTIONAL. ATTACH ADDITIONAL SHEET IF NECESSARY)

_____

_____

_____

_____

_____
(NAME OF PERSON PREPARING SUMMARY. PLEASE PRINT)

_____
(SIGNATURE OF PERSON PREPARING SUMMARY)

_____
(TITLE) (DATE)

PAGE 6 (SUPPLEMENTAL)

SECTION V: "MEDICALLY RELATED APPEALS" INFORMATION

DATE OF APPLICATION OR REVIEW: _____

DATE MEDICAL HISTORY & DISABILITY REPORT SUBMITTED TO MDU: _____

DATE DISABILITY REFERRAL FORM SUBMITTED TO MDU: _____

MDU RESULTS: _____

WERE DISABILITY EXCEPTIONS EVALUATED? BY WHOM? INDICATE RESULTS OF EVALUATION:

_____

_____

_____

_____

DATE OF SSA/SSI DECISION: _____

IS APPLICANT CURRENTLY RECEIVING SSA/SSI? _____

LIST ALL OTHER CATEGORIES EVALUATED AND INDICATE WHY THEY WERE NOT MET OR DO NOT APPLY:

_____

_____

_____

_____

DATE OF PERSONAL CARE OR MEDICAL MANAGEMENT NOTICE: _____

WAS AGENCY WORKER DIRECTLY INVOLVED IN DECISION? RESULTS OF PARTICIPATION:

_____

_____

_____

ATTACH COPIES OF MEDICAL HISTORY AND DISABILITY REPORT, DISABILITY REFERRAL FORM, PERSONAL CARE, MEDICAL MANAGEMENT, AND ANY SSA/SSI NOTICES AND DECISIONS.

AGENCY APPEAL SUMMARY

FORM NUMBER - 032-03-805

PURPOSE OF FORM - To provide information to DMAS about case when an action of an eligibility worker on a Medicaid, SLH, *or FAMIS* case is being appealed.

NUMBER OF COPIES - See detailed instructions below.

DISPOSITION OF FORM - See detailed instructions below.

INSTRUCTIONS FOR PREPARATION OF FORM - To print this form, first print position should be 5, line spacing should be b, and pitch should be 12. See detailed instructions below for completing the form.

1. The "Agency Appeal Summary" must be prepared by the individual who took action on the case. If that individual is not available to complete the summary, it must be so stated, with an explanation provided.

2. Answer all questions in the "case identification" and "general information" sections and all questions in the section relating to the specific issue(s) of the appeal. If a pre-hearing conference is held, details of the conference should be included in the summary. If a question is not applicable, so indicate by N/A.

3. Any page or section of the "Agency Appeal Summary" form which is not relevant to the appeal should be omitted. The form may be typed, computerized, or handwritten, but cannot be altered or modified in any form.

4. The worker can complete a narrative summarizing the information contained in the other parts of the summary, and containing relevant background information pertinent to the case action. This may assist the local DSS representative in presenting testimony at the hearing.

5. Show all calculations used to reach values upon which the action was based. Computations should be shown in the "Agency Appeal Summary", on a separate sheet, or may be added to the bottom of the narrative.

6. On appeals in which the action was taken by another agency, and the local DSS only provided appropriate notices to the claimant or evaluated the "disability exceptions", the worker is required to complete only the "case identification" and "general information" sections of the summary and the "medically related" section relevant to the action taken by the local DSS.

7. Attach copies of all relevant documentation and verifications, including (but not limited to), those listed in the "general eligibility" section of the "Agency Appeal Summary". It is not necessary to label attachments for identification on the document. Exhibit labeling will be done by the hearing officer. A cover sheet identifying attachments is sufficient.

8. Distribute copies of the "Agency Appeal Summary" following the instructions in the "Agency Request" letter to the following:

(1) the claimant and his/her representative,

(2) the *local agency's assigned Medicaid Program Consultant, and*

(3) Department of Medical Assistance Services
Division of Client Appeals
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Note: The claimant's entire case record must be available to the claimant and his/her representative. If the case record contains medical records marked "Confidential", restricting patient access, do not provide claimant access to those records without written authorization of the physician.